

Children in Foster Care: The Effect of Age and Multiple Placement Disruption on
Psychopathology

Melissa Giaquinta
Master of Psychology (Clinical)

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I declare that this thesis is my own work and that, to the best of my knowledge and belief, it does not contain material from published sources without proper acknowledgement, nor does it contain material which has been accepted for the award of any other higher degree or graduate diploma in any university.

Signed _____

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Table of Contents

List of Tables.....	v
Abstract	1
Introduction	2
Out-of-Home-Care	3
Psychopathology among Foster Care Children.....	6
The Role of Multiple Placement Disruption	13
The Influence of Reunification on Psychopathology	17
The Influence of Age on Psychopathology	21
Aims of the Present Study	24
Hypotheses	25
Method	26
Participants	26
Materials	26
Child Behaviour Checklist	26
Procedure	27
Statistical Procedures	28
Results	29
Data Screening	30
Descriptive Statistics of Study Variables	31
Relationship between Foster Care Status and Psychopathology	35
Relationship between Age and Psychopathology	37
Discussion	37
Relationship between Foster Care Status and Psychopathology	38
Relationship between Age and Psychopathology	45
Limitations of the Study	46
Direction for Future Research	47
Conclusion	48
References	50

List of Tables.

Table 1	Means and Standard Deviations for CBCL Subscale T-scores in Relation to Foster care Status.....	32
Table 2	Means and Standard Deviations for CBCL Subscale T-Scores in Relation to Age.....	34

Abstract

Unfortunately, a large number of children are subjected to abuse or neglect in their family home, rendering such environments unsuitable. Foster care is an alternative living arrangement organised by Child Protection Services provided to some of these maltreated children. In order to advocate for the wellbeing of children in foster care, it is essential to gain insight into the factors that influence psychological adjustment in the foster care system. The present study aimed to explore the influence of multiple placement disruption, reunification, and age, on the psychopathology of children in foster care. The study utilised a clinical sample to compare the severity of symptoms among children in foster care, and children who had never experienced foster care. Findings indicated that overall, children and adolescents who had experienced multiple foster care placements, or had been successfully reunified, demonstrated more severe psychopathological symptoms in comparison to those who had never experienced foster care. Further, externalising symptoms were found to be more prevalent among foster care children than internalising symptoms. Regarding age, no significant difference was found between children and adolescents for the experience of psychopathological problems. Findings and implications for further research are discussed.

Although all children deserve unconditional love, nurturance and respect from their parents, the concerning reality is that a large number of children and adolescents are subjected to child abuse or neglect (Shulman, 2005). The Australian Institute of Family Studies defines child abuse as any unconventional behaviour towards children and young people that poses considerable risk of the experience of physical or emotional harm. Such maltreatment may be intentional or unintentional and may be initiated by a parent, caregiver, adult, or older adolescent. Maltreatment may take the form of physical abuse, emotional maltreatment, neglect, sexual abuse, or the witnessing of family violence (Australian Institute of Family Studies, 2013).

The prevalence of child abuse in Australia is problematic and concerning. According to the Australian Institute of Health and Welfare (AIWH, 2013), a total of 252,962 children across Australia were suspected of being subjected to either abuse or neglect between 2011 and 2012, based on the number of notifications made to Child Protection Services. This equates to a rate of 30 children per 1,000. A total of 48,420 of these suspected abuse or neglect cases were confirmed. Presumably there would also be a large number of cases of abuse that have gone unrecognised or unreported.

In Australia, Child Protection Services provides assistance to those children who have been exposed to abuse, neglect, or harm. Assistance is also provided to children who may be at risk of these experiences. Specifically, assistance may involve removing the child from their threatening environment and providing them with alternative care arrangements. Between June 2011 and June 2012, 14,191 children required Child Protection Intervention following a notification. At the 30th of June 2012, a total of 40,962 children were the subject of a care and protection order in Australia (AIWH, 2013).

Given the prevalence of child abuse and the large number of children requiring assistance, there exists a need for insight into the impact of out-of-home care on children and adolescents, in order to ensure the best approaches are taken to facilitate good psychological adjustment for these individuals. The current study endeavours to explore the impact of foster care on the psychopathology among children and adolescents. Further, the study aims to delineate the impact of multiple placement disruptions and reunification on the psychopathology of children and adolescents in foster care. Finally, the study will assess the influence of age on psychopathology among foster care children.

Out-of-Home Care

For a number of children, certain circumstances render their family home an unsuitable environment for them in which to reside. For such individuals, out-of-home care (OOHC) provides an alternative source of guardian support. OOHC denotes a short or long-term placement whereby a child up to the age of 18 years is cared for by a caregiver other than their biological parents (Victorian Department of Human Services, 2007). Several OOHC options are available including foster care, kinship care, permanent care, and residential care.

The process by which a child enters an OOHC placement often begins when a child is perceived to be unsafe and a notification is made to Child Services. Depending on the nature of the notification, circumstances deemed high risk may warrant immediate removal of the child from their home environment proceeded by placement in an OOHC arrangement. However, predominantly, the notification is initially assessed to determine whether further investigation is required. Upon investigation, a case is either 'substantiated' or 'not substantiated' whereby

substantiation indicates that the child is at risk. When an investigation indicates that the child is not receiving adequate care in the home environment they are taken into OOHC and a court order is sought, outlining the conditions of the parents' rights to care. Parents are required to address identified risk factors in cases where reunification is deemed a possibility. Otherwise, the child can remain in OOHC until the age of 18 years (Parliament of Tasmania, 2001). Alternatively, a small number of children enter the OOHC system voluntarily. Such informal placements may be arranged by a child protection employee or by a Community Service Organisation, or sought by a parent (AIHW, 2005; Victorian Department of Human Services, 2007).

A worrying trend exists in that the rate of Australian children in the OOHC system is increasing. At the 30th of June in 2007, a total of 28,379 Australian minors were in OOHC. A steady annual increase had led to a total of 37,648 children in OOHC at the 30th of June, in 2011. Such figures denote a ratio increase from 5.8 to 7.3 per 1,000 children in the OOHC system (Australian Institute of Health and Welfare, 2012). Statistics indicate a further increase in OOHC placement, with 7.7 per 1,000 children reportedly in OOHC at June 30th, 2012 (Australian Institute of Health and Welfare, 2013). In Australia, the number of substantiated abuse cases leading to OOHC intervention has decreased since 1999, conceivably due to the increase in implementation of early intervention programs for familial support. However, the number of individuals within the OOHC system has increased given that a larger number of children and adolescents enter the OOHC system in comparison to those who are discharged from Child Protection intervention (Australian Institute of Health and Welfare, 2009; Taplin, 2005).

Of those requiring alternative care, a considerable number of children are placed in foster care. Indeed, at June 30th 2012, 36% of Australian children in OOHC were living in a foster care arrangement. This percentage was higher than the percentage of children residing within other forms of OOHC. Foster care specifically involves receiving care from an individual who is authorised as a caregiver, known as a 'foster carer'. The length of stay in a foster care arrangement may range from overnight to a number of years. Reunification remains the primary goal of foster care intervention, however, in some cases the adverse nature of the home environment prevents such return. In these cases the child may stay in foster care until they are an adult (Australian Institute of Health and Welfare, 2013).

Children may require foster care for a number of reasons; for example, they require a more protective environment, their parents are not providing sufficient care, or their family environments are characterised by conflict (Australian Institute of Health and Welfare, 2013). The predominant familial history for children within the OOHC system involves persistent maltreatment, such as, parental abuse or neglect (Bruskas, 2008; DosReis, Zito, Safer, & Soeken, 2001; Dubner & Motta, 1999; Iglehart, 1993; Kerker & Dore, 2006; Oswald, Heil, & Goldbeck, 2010; Strijker & Knorth, 2009).

A literature review by Oswald and colleagues (2010) examined the history and development of foster care children, utilising results from 32 empirically based studies. Disconcertingly, Oswald and colleagues reported the majority of foster care children to have been exposed to a range of differing maltreatments prior to Child Services intervention. Specifically, neglect was reported as one of the most common forms of maltreatment with rates ranging from 18-78%. Physical abuse and sexual abuse were also common forms of maltreatment experienced, where rates ranged

from 6-48%, and 4-35%, respectively. In New Zealand in 2012, neglect was identified as the most common reason for a child protection notification, followed by physical abuse, sexual abuse, and emotional abuse (New Zealand Government, 2013). In Australia, between 2011 and 2012, 36% of substantiated Child Services notifications were found to involve emotional forms of abuse. Moreover, 31% were found to involve neglect whereas 12% involved sexual abuse. Cases involving physical abuse were found to range from 13% to 29% across different jurisdictions (Australian Institute of Health and Welfare, 2013).

Evidently, children who enter a foster care placement often have been exposed to undesirable and traumatic circumstances rendering them vulnerable to psychological maladjustment. Further, the number of children residing in foster care placements is increasing over time, with a larger portion of children entering the Child Protection system compared to those that are discharged. Such increase in the number of foster care children coupled with their psychological vulnerability, highlights the need to gain insight into the adjustment of children in foster care. Endeavouring for more positive experiences within the foster care system, gaining an in-depth understanding of the impact of foster care on children's wellbeing will ultimately allow for insight into the needs of such children,

Psychopathology among Foster Care Children

Due to the adverse situations precipitating OOHC, children in the foster care system experience an elevated risk of experiencing mental health problems (Gries, 1986). Indeed, previous literature has demonstrated quite a high prevalence rate of mental health problems among children within the foster care system, with rates reportedly ranging between approximately 31.7% and 80% (Burge, 2007; Clausen,

Landsverk, Ganger, Chadwick, & Litrownik, 1998; Holtan, Ronning, Handegard, & Sourander, 2005; Minnis, Everett, Pelosi, Dunn, & Knapp, 2006; NSCAW, 2002; Sawyer, Carbone, Searle, & Robinson, 2007; Tarren-Sweeny, & Hazell, 2006; Zima, Bussing, Yang, & Belin, 2000).

Specifically, a study by Clausen et al. (1998) assessed the wellbeing of 267 foster care children. Scores from the Parent Report Form (PRF) of the Child Behaviour Check List (CBCL; Achenbach, & Edelbrock, 1986) indicated that between 42.5% and 50.0% of participants aged between 4 and 16 years scored above the clinical range for behavioural and emotional problems. Additionally, between 50.0% and 66.7% of participants yielded scores within the borderline range. Tarren-Sweeny and Hazell (2006) also utilised the CBCL to explore the mental health of children within foster care and kinship care. Of those who were assessed, 51% of children in foster care were reported to have behavioural and emotional problems within the clinical range. Additionally, 57% of foster care children were demonstrated to have mental health issues within the borderline range.

Similarly, Sawyer and colleagues (2007) found that 61% of their sample was characterized by significant behavioural and emotional problems as denoted by the PRF. Further, 35.2% of adolescent participants reported significant mental health symptoms as indicated by the Youth Self Report form (YSR). The Department of Health and Human Services (DHHS) conducted a comprehensive longitudinal study, titled the National Survey of Children and Adolescent Well-Being (NSCAW, 2002), which focused on the wellbeing of children in the Child Welfare system. Data indicated that 33.4% of foster care participants attained CBCL scores above the clinical level.

It is unsurprising that high rates of behavioural and emotional problems are apparent among the foster care population due to the negative environmental factors commonly present prior to entering the foster care system. In particular, foster care children have often been exposed to maltreatment such as physical abuse, sexual abuse, emotional abuse, and/or neglect, prior to receiving Child Protection intervention (Oswald and colleagues (2010). Such maltreatment may negatively impact the adjustment, and ultimately the mental wellbeing, of individuals who have endured such trauma (Bruskas, 2008).

Previous research also has also demonstrated that children in the foster care system are more likely to suffer from psychological symptoms in comparison to children who live at home and have never experienced OOHC (Kerker & Dore, 2006). Sawyer et al. (2007) explored the rate of clinically significant psychological symptoms among both foster care and community populations. A higher proportion of children in the foster care group had clinically significant psychological symptoms, with 60.1% of children demonstrating behavioural problems, and 44.9% demonstrating emotional symptoms. Comparatively, 12.7% of children within the community sample reported behavioural problems, whereas 13.3% experienced emotional problems. Overall, the experience of total psychological problems was reported to be up to 4 times higher for children in foster care than for those living at home, with scores of 61.0%, and 14.1%, respectively.

Research by Stein, Evans, Mazumdar, and Rae-Grant (1996) compared the psychiatric wellbeing of children in foster care to a community sample, and a clinical sample recruited from a children's mental health centre. Results indicated that children in foster care experienced a significantly greater number of psychological symptoms than children in the community. The difference between the mental health

status of children in foster care and children in clinical care was minimal. Stein and colleagues concluded that the similarity of findings between the foster care sample and the clinical sample highlights the importance of attending to the mental health care needs of children in foster care.

Harman, Childs, and Kelleher (2000) explored the psychopathology and utilisation of mental health services among foster care children, and children residing with their biological parents, who were receiving Medicaid. Medicaid refers to the US government's insurance program available to low income families who require financial assistance to pay for health care. Harman and colleagues concluded that children in foster care were 3 to 10 times more likely to suffer a mental health problem, including diagnoses of Depression, Anxiety disorders, Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, Bipolar Disorder, and Oppositional Defiance. Foster care children additionally had 6.5 times more mental health care claims made for them in comparison to other children, with regard to the number of services they utilised. Further, foster care children were admitted to hospital 7.5 times more frequently for mental health related issues. Such results undoubtedly raise concern regarding the welfare of children within the foster care system.

Kortenkamp and Ehrle (2002) explored the psychological adjustment and school experiences of children who either resided with their parents, were in high-risk parent care, or were being cared for in a Welfare placement. Kortenkamp and Ehrle determined that in comparison to children in parental care, children involved with Child Welfare experienced, on average, higher levels of behavioural and emotional problems, engaged less well at school, and were subject to school suspension or expulsion more often. It is difficult to discern whether these children

may have been in foster care due to their psychological problems, or if they developed such problems due to their foster care experience. Furthermore, such issues were experienced more frequently by children in the Welfare system than by those who were under the care of their parents in a high-risk home environment. The latter result seems counterintuitive and evokes question about the impact on children being raised in a foster care environment. It may be anticipated that removing a child from an abusive and risky home environment and placing him/her into a healthier home environment would represent a positive change for the young individual. Rather, there may be discernible negative consequences of a change in living situation that may have an impact on the child. An attachment theory perspective may provide some insight into why this is the case.

As described by Bowlby (1969/1982), attachment theory essentially postulates that an infant develops a biologically based bond to their primary caregiver/s, and such attachment influences the child's development. The kind of responses the individual receives from their primary care giver/s influences the development of a pattern of attachment, which later impacts on relationship development and quality. Children who are involved in an abusive relationship are likely to experience difficulty in developing appropriate attachments to the abusive perpetrator. For example, Young and Gersen (1991) posited that children who are subjected to intermittent abuse may become more strongly attached to their perpetrator, learning that the abuse must be endured in order to sustain the attachment.

Charles and Matheson (1990) proposed that children who have experienced difficulty in developing healthy attachments, who are then removed from the home and placed into a foster care home, tend to experience exacerbated symptoms of

distress. Charles and Matheson suggested that such increase in distress is attributable to an inability to separate in a healthy manner and, further, that being separated from the primary caregivers is in itself a trauma for the child. When experiencing fear due to trauma, children are likely to cling to their primary care giver, even if the caregiver is responsible for inducing such fear (Salo, 2006). Many negative emotions may be experienced by the child upon transition into a foster care home; rejection, guilt, anger, hostility, self-blame, shame, low self-esteem, feelings of abandonment, stress, confusion, and dissociative reactions (Katz, 1987; Mitchell, Kuczynski, Tubbs, & Ross, 2010). Such negative factors may facilitate the manifestation or exacerbation of existing mental health problems.

Evidently, many children within the foster care system experience psychopathological symptoms (Burge, 2007). Throughout the literature, externalising symptoms are reportedly experienced more predominantly in comparison to internalising symptoms (e.g., Clausen et al., 1998; NSCAW, 2012; Steele & Buchi, 2008; Tarren-Sweeny & Hazell, 2006). Externalising symptoms denote those which are directed outwardly, such as, aggression, defiance, delinquency, and hyperactivity. Internalising symptoms are characterised by problems which are directed inwardly, such as, social withdrawal, anxiety, depression, and somatic problems.

According to the National Survey of Child and Adolescent Well-Being (NSCAW, 2012), 18.7% of foster care children demonstrated significant externalising problems, compared to 14.3% possessing significant internalising problems. Similarly, Tarren-Sweeny and Hazell (2006) found 43% of foster care children experienced significant externalising symptoms, whereas 22% of children experienced significant internalising symptoms.

Furthermore, a study by Harman et al. (2002) reported a higher percentage of externalising disorders (ADHD = 14.7%, Conduct Disorder = 4.5%, Oppositional Defiant Disorder = 9.4%) than internalising disorders (Anxiety = 2.5%, Bipolar Disorder = 1.0%) among children in foster care. However, Depression (5.9%) was reportedly as common as the externalising disorders.

Foster care children's undesirable familial history and experience of separation trauma may collectively play a significant role in the predominance of externalising symptoms over internalising symptoms. Regarding maltreatment often found present in the history of foster care children, research has indicated that the experience of physical abuse is strongly linked with externalising symptomatology (e.g., Jaffee, Caspi, Moffit, & Taylor, 2004; Kaufman & Cicchetti, 1989; Levendosky, et al., 2006; Rogosch & Cicchetti, 1994.; Williamson, Borduin, & Howe, 1991).

However, Williamson, Borduin, and Howe (1991) concluded that neglect and sexual abuse are more strongly associated with internalising symptoms than externalising symptoms. Given that neglect is reportedly the most common form of maltreatment experienced among foster care children (Oswald, Heil, & Goldbeck, 2010), it would appear intuitive that internalising symptoms would then be more prevalent among foster care children. However, Higgins (2004) expressed that children who experience familial maltreatment are rarely exposed to one form of abuse or neglect, whereby multiple forms of maltreatment are often endured. Therefore, children who are neglected or sexually abused may also be exposed to physical abused at times, increasing their risk of externalising symptoms.

Moreover, the occurrence of separation trauma in addition to maltreatment may provide further insight into why externalising symptoms are more common among this cohort, despite the link between neglect and internalising symptoms. Indeed, studies have shown that insecure and disorganised attachment patterns often lead to externalising symptomatology in children (e.g., Munson, McMahon, & Spieker, 2001; Ruth, 1996; Smeekens, Riksen-Walraven, & van Bakel, 2007). Foster care children are not only exposed to the insecure parent-child attachment styles associated with maltreatment, but also experience the separation of parent-child attachment involved in removing the child from their biological home.

Overall, it is evident that the risk of psychopathology is quite high among foster care children due to the adverse familial situations rendering foster care necessary. Further, externalising behavioural problems tend to be more prevalent among the foster care cohort, perhaps due to their experience with maltreatment, and the attachment trauma associated with abuse and removal from parental care. Given that both internalising and externalising symptoms are associated with the foster care system, and that attachment trauma plays a role in the negative mental wellbeing of children, it is important to consider the impact of multiple foster care placement experiences on a child's psychological and behavioural wellbeing.

The Role of Multiple Placement Disruption

During their time within the foster care system, children may be moved from one foster placement to another. According to a study by Delfabbro, Barber, and Cooper (2001), 20% of children in OOHC in South Australia experienced between three and five placements. Moreover, 18% were moved between six and nine

placements, and a large number of children, 24%, had been in 10 or more placements during their time in the foster care system.

Delfabbro, Barber, and Cooper (2001) identified four main reasons for the breakdown of foster care placements; biological-family related (e.g., when there is conflict between the biological and foster family), foster-family related (e.g., stressors within the family, complaints against the foster family), system or policy related (e.g., lack of funding, or routine procedures such as moving the child from a shelter to a short-term placement), and behaviour-related problems (e.g., disruptive or emotional problems expressed by the child or adolescent). Research has indicated that placement instability and the experience of multiple placements increases the risk for negative mental health outcomes in children (e.g., Fisher, Stoolmiller, Mannering, Takahashi, & Chamberlain, 2011; Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007; Newton et al., 2000; Taussig, Clymen, & Lardsverk, 2001).

Specifically, Lewis and colleagues (2007) found that within a sample of adopted foster care children, individuals who had experienced multiple foster care placements demonstrated poorer inhibitory control and more oppositional behaviours in comparison to those who had experienced stable foster care placements. Moreover, evidence has suggested that children who experience multiple changes in placement are at an elevated risk of developing both internalising and externalising behavioural problems. Additionally, children who initially have behavioural problems are particularly vulnerable to an increase in psychological symptoms as a result of multiple placements (Newton et al., 2000; Taussig et al., 2001). Conversely, placement stability may lead to positive outcomes. Maunders and colleagues (1999)

indicated that a stable experience in OOHC positively impacts on the individual's ability to adjust to independent living after leaving foster care.

When considering placement instability, studies have suggested that externalising behaviours are a significant risk factor for multiple placement disruptions in foster care (e.g., Fisher et al., 2005; Fisher et al., 2011; James, 2004; Leathers, 2006; Price et al., 2008). A study by Fisher and colleagues (2011) assessed the threshold for the number of problematic behaviours that predicted risk of placement disruption. Their sample comprised foster care children and children in foster care who were receiving a family-based treatment intervention. Results indicated that for foster care children who did not receive intervention, experiencing over five behavioural problems posed a risk for placement disruption, with risk specifically increasing 10% exponentially for each additional problem. However, the number of problem behaviours in the foster care children receiving intervention did not predict placement disruption. This indicates that early intervention, indeed, is important for children to experience positive stability in the foster care system. As concluded by Fisher and colleagues, equipping foster carers with specific behaviour management skills allows the carer to appropriately deal with the foster child's maladjusted behaviour. As such, problem behaviours may be reduced and the risk of placement breakdown is lowered.

Delfabbro, Barber, and Cooper (2001) reported that adolescents with conduct problems are particularly vulnerable to unsatisfactory placement transition and multiple placement breakdowns, and concluded that such adolescents are unsuited to foster care. Similarly, James (2004) reported that the three main risks associated with behaviour related placement breakdown are being of an older age at foster care entry,

possessing externalising problems, and past experience of abuse in the biological home

It may be anticipated that being of an older age at entry into foster care is a risk factor based on the contention that older aged children may have been exposed to familial maltreatment for a longer period of time, in comparison to individuals whose abuse is recognised earlier in their development, warranting entry into foster care at an earlier age. Given that prolonged exposure to abuse has detrimental effects on mental wellbeing, older aged children are at risk of entering the foster care system with severe behavioural problems (Iglehart, 1993). Additionally, research indicates that older aged children have particular difficulty adjusting to the foster care system (Delfabbro, Barber, & Cooper, 2001).

Newton et al. (2000) concluded that behavioural problems both cause, and are a consequence of, placement breakdowns. That is, experiencing a failed placement may contribute to externalising and internalising symptomatology, and concurrently, manifesting such symptoms may lead to the placement failure. Indeed, a vicious cycle is apparent whereby children with behavioural and emotional problems are more likely to experience increasing instability in the foster care system. Such an adverse cycle may be explained in terms of problems associated with attachment to caregivers.

As described earlier, children who are removed from their biological home often experience difficulty in adjusting to the separation from their parents. Such attachment disruption is often traumatising and results in a distressing experience (Charles & Matheson, 1990). Many of the negative emotions associated with entry into foster care, such as abandonment, guilt, and anger, lead to the manifestation or exacerbation of internalising and externalising symptomatology. It may be postulated

that each placement disruption presents an additional breakdown in attachment to primary caregiver/s, characterising an additional trauma for the child or adolescent. Consequently, the individual's level of distress is increased, their emotional and behavioural problems exacerbated, and their risk of experiencing an additional placement breakdown due to behavioural reasons is heightened.

Overall, there exists a strong evidence base indicating that the experience of psychological problems renders an individual in foster care more vulnerable to experiencing a placement breakdown. Concurrently, the experience of multiple placement disruptions represents a traumatic experience in the child's life which renders them vulnerable to the development or exacerbation of psychological problems. Although the experience of multiple foster care placements evidently negatively impacts on children's and adolescents' psychological wellbeing, a question must be raised about the impact of reunification, given that the transition from a foster care home to the home of the child's biological parents, in itself, is characteristic of an additional attachment trauma.

The Influence of Reunification on Psychopathology

The primary goal of child protection intervention is to reunite the child with their biological parents when and if it is safe for the child to return (Smyth & Eardley, 2008). Family reunification is based on the premise that it is important for children to reside with their biological family, and that parents potentially have the capacity to adequately care for their child/children if assisted (Maluccio, Warsh, & Pine, 1993). The decision to reunify a child with his or her biological parents is based on the competency of the parents, which often requires certain rehabilitation processes to be undertaken, and certain conditions to be met. The effects of

reunification on children have been described as complex, with both potentially beneficial and damaging outcomes apparent (Lau, Litrownik, Newton, & Lardsverk, 2003).

Certainly, it has been suggested that reunification can lead to poorer outcomes. Behavioural and emotional problems have been shown to worsen in children who are reunified in comparison to children who remain in foster care (Taussig et al., 2001). Presumably, children may be returning home to a volatile environment. Although the requirement of reunification involves the parents' rehabilitation of any adverse situations that precipitated the child's removal from their care, research has shown that children who return home to a previously negative home environment are often re-exposed to abuse and neglect (Terling, 1999).

Taussig et al. (2001) conducted a study that aimed to investigate the outcomes associated with family reunification of foster care children compared with those remaining in the child protection system. Taussig and colleagues reported that children who had been reunified displayed a significantly greater severity of problems relating to internalizing problems, total behaviour problems, self-destructive behaviour, high risk behaviours, criminal behaviours, academic performance, school drop-out, and overall competency. Results indicated no significant difference between both groups with regard to some externalizing behaviours, specifically, delinquency, sexual behaviours, pregnancy, or suspensions. It was postulated that the environments in which the reunified children were returning to may have been characterised by inadequate parenting, providing an explanation for the exacerbated symptoms of the reunified foster care children.

Research has indicated that children who are reunified may be returning to an adverse environment in which they may be exposed to a number of risk factors that impede adjustment. Such risk factors may include exposure to violence, maternal health problems, poor family functioning, and decreased parental support (Litrownik, Newton, Mitchell, Richardson, & Lardsverk, 2003).

Interestingly, a study by Lau and colleagues (2003) found that internalising problems were not directly affected by reunification. However, they concluded that reunification lead to an increase in exposure to negative and stressful life events, which indirectly exacerbated internalising symptoms. They further identified that reunified children were less likely to access mental health services, suggesting that their psychological wellbeing may not be adequately monitored or managed. Conversely, some positive outcomes of reunification were identified; decline in feelings of social isolation, lower social dissatisfaction, and an increased sense of access to adult support.

Due to past research suggesting that multiple placements may lead to an increased risk in psychological problems, it could be argued that failed reunification attempts are detrimental to the child's mental health and wellbeing. Wulczyn (2004) stated that a significant number of children who are reunified with their parents often re-enter the foster care system. Based on data from Chicago, Wulczyn reported that in 1990, approximately 30% of foster children who were reunified with their families returned to a foster placement within 10 years. Cordero (2004) utilised a data mining approach to explore foster care records in order to gain insight into family reunification. Cordero described four main barriers to reunification; compromised parent-child relationship, placement separation anxiety, domestic violence and substance use, and an impending unplanned birth in the biological home. Re-entry

into foster care may be a result of the family's inability to adequately cope with the stresses or problems that arise through the reunification process, often when there is a lack of assistance in dealing with such difficulties (Cordero, 2004).

Panozzo, Osborn, and Bromfield (2007) reviewed Australian studies addressing factors influencing reunification. The review indicated that the biological parents of foster care children often feel threatened and confused by the child protection system. Further, they emphasised the importance of providing consistent support to parents to assist with the child protection process.

Collectively, research has indicated that the reunification process is both complex and potentially damaging to the child's wellbeing. The separation trauma associated with moving a child from a foster home back into the care of their parents, in combination with a lack of support offered to biological parents, and the child's potential increased exposure to adverse environmental factors, all appear to play a detrimental role with regard to the child's psychopathology. Often, children who are reunified experience an increase in behavioural and psychological symptoms which may be due to such adverse factors involved in the reunification process. In some cases, children are returned to the foster care system following a reunification attempt, increasing their experience of separation trauma. However, positive experiences have also been associated with reunification, such as children's decreased sense of isolation. Further research into the impact of reunification on psychopathology is necessary to elucidate the suitability of reunification as the primary goal of foster care intervention.

Indeed, a range of factors influencing the psychological wellbeing of foster care children have been identified. Previous literature has indicated age to be one of these influencing factors.

The Influence of Age on Psychopathology

Leading up to adulthood, different ages are associated with different milestones and present challenges to be faced (Burke, 2006). Given these differing experiences at different ages, it may be postulated that age would have an impact on a child's ability to adjust to the processes of child protection intervention. Some studies have shown that age influences the development of psychopathology symptoms in foster children (e.g., Janssens & Deboutte, 2010; Steele & Buchi, 2008), although such literature appears to be scarce. Further, existing research is somewhat confusing and contradictory in nature.

Some research has found evidence of younger aged children possessing higher rates of psychopathology than older children. A study by Sawyer et al. (2007) reported that foster children aged 6 to 12 years possessed higher rates of attention and social problems in comparison to foster children aged 13 to 17 years. Similarly, Vandivere, Chalk, and Moore (2003) indicated that 47% of children aged between 6 and 11 years met the diagnostic criteria for psychological and behavioural disorders, in comparison to 40% of children who were aged between 12 and 14 years. Collectively, these findings suggest that children of middle age range may be at a higher risk of experiencing psychopathological problems, compared to adolescents.

Contrarily, research has suggested that mental health problems are more prevalent among older aged foster care children. The National Survey of Child and Adolescent Well-Being (NSCAW, 2003) utilised the CBCL to assess behavioural problems of children and adolescents who had been in foster care for one year. Results indicated that 51% of four to 18 year olds reached the clinical level for externalising problems, compared to 24% of 2 to 3 year olds. In contrast, 31% of 4 to

18 year olds reached the clinical level for internalising problems, compared to 28% of 2 to 3 year olds. Steele and Buchi (2008) explored the mental wellbeing of foster care children and found that the percentage of participants possessing a mental health condition increased exponentially with each age category, namely, 0 to <3, 3 to 5, 6 to 12, and 13 to 18 years.

In a study by Janssens and Deboutte (2010), adolescents, in general, were characterised by a higher percentage of above clinical cut-off scores on the Strengths and Difficulties Questionnaire, according to the parents' report (3-5 years = 29.2%; 6-11 years = 50%; 12-17 years = 54.4%). However, this differed from the scores resulting from the agency carer report form (3-5 years = 28%; 6-11 years = 45.1%; 12-17 years = 44.5%). Only 18% of adolescents identified themselves as possessing mental health problems. Overall, the difference between age groups was not significant.

However, Tarren-Sweeny and Hazell (2006) concluded that the higher rate of psychopathology among older aged children reported in existing literature may be confounded by the fact that some individuals enter foster care at an older age and often have pre-existing mental health conditions prior to entry. It also has been found that adolescents who enter the foster care system at an older age are at higher risk of presenting with maladjusted externalising behaviours (Iglehart, 1993), which lends support to Tarren-Sweeny and Hazell's postulation outlined above.

Evidently, the existing literature is conflicting in that research supports both contentions that foster care children of a middle age range, and adolescent foster care children, are more likely to experience psychological and behavioural problems. While it is difficult to determine the reason for the conflicting nature of the current literature, it may be postulated that the method of attaining data may play a role in

the contradictory findings. For example, studies tended to utilise the CBCL to attain information, whereby some researchers' analysed information reported from multiple sources such as the biological parent, the foster carer, and the adolescent. Utilising self-report responses from multiple sources may have significantly impacted the interpretation of results, given the inconsistency often found between parent, teacher, and adolescent responses on the CBCL (Phares, Compas, & Howell, 1989)

Additionally, there lacks a consistency in the specific age cohorts assessed across the different studies. An age deemed 'older' in one study may overlap with an age deemed 'younger' in an alternative study, leading to difficulty in comparing study results. A further criticism of the existing literature is that while studies have assessed the rate of psychopathology among foster care children of differing age cohorts, information is lacking about the severity of problems experienced among the different age categories.

Past research may allude to the postulation that adolescent foster care children are at a greater risk of experiencing more severe psychopathological symptoms, in comparison to younger foster care children. Studies have reported that older children are at an elevated risk of experiencing placement disruption in comparison to younger children (Fratter, Rowe, Sapsford, & Thoburn, 1991; Rowe, Hundleby, & Garnett, 1989). Based on the literature suggesting that externalising symptoms predict multiple placement breakdowns, it may be postulated that older foster care children exhibit higher rates of psychopathology symptoms which, in turn, increases their risk of experiencing multiple placement disruption. Indeed, Jones (1987) proposed that older children in foster care who experience a higher severity of behavioural problems are at a greater risk of experiencing placement

instability. Moreover, Delfabbro, Barber, and Cooper (2001) found that adolescents were less likely to successfully transition to foster care in comparison to younger children.

Further, adolescents' elevated risk of experiencing placement disruption renders them more vulnerable to the manifestation or exacerbation of psychological symptoms which is often associated with the breakdown of foster placements (e.g., Fratter, Rowe, Sapsford, & Thoburn, 1991; Taussig et al., 2001). Such risk factors associated with adolescent aged foster care children may render this age cohort more vulnerable to experiencing behavioural and psychological problems at a greater degree of severity, in comparison to younger aged foster care children.

Evidently, the current available literature is limited and conflicting. A larger research base is required to gain further insight and clarity into the relationship between age and psychopathology among children in the foster care system. Specifically, it is important to elucidate not only the rate of psychopathology among differing age cohorts, but also the severity of symptomatology experienced by foster care children in different developmental stages.

Aims of the Present Study

The present study was designed to explore the effects of foster care on child psychopathology symptoms. Specifically, the study aimed to expand on current literature regarding the risk of psychopathology among foster care children. Existing research tends to investigate the prevalence rate of psychopathology among foster care children as compared with those who reside with their biological parents. This study aimed to expand on such literature by focusing on comparing the severity of mental health symptomatology of children in foster care with children who had never

been involved in OOHC, using a sample of children and adolescents with existing psychological and behavioural problems. Furthermore, the study endeavours to utilise a clinical sample in order to account for the fact that some children and adolescents may have pre-existing mental health conditions prior to entry into foster care, which has been a criticism of past research regarding the influence of age on psychopathology.

A further aim was to assess the impact of multiple placement disruption on the psychopathology of foster children, in addition to investigating the influence of reunification with the child's biological parents. A final endeavour of the study was to elucidate the impact of age as a factor influencing mental wellbeing among foster care children, with the aspiration of providing further clarity into the existing contradictory research.

Hypotheses

Based on previous research, two research outcomes were anticipated. It was hypothesised that children and adolescents who had experienced multiple foster care placements would attain the highest scores on a measure of behavioural problems, followed by children and adolescents who had successfully been reunified, children and adolescents who had experienced one foster care placement, and children and adolescents who had never experienced OOHC, respectively. It was further expected that externalising symptoms would be more prevalent than internalizing symptoms.

Secondly, it was hypothesised that children in the adolescent age range would possess higher scores on a measure of psychopathological symptoms in comparison to those in the middle childhood range, and those in the young children's range, respectively.

Method

Participants

All data were archived from the Academic Child Psychiatry Unit (ACPU) of the Royal Children's Hospital based in Melbourne, Australia. The ACPU is an out-patient psychiatric unit dealing specifically with the psychological issues of children and adolescents. The sample comprised 1,524 children and adolescents who were referred and assessed because of reported psychiatric problems.

Within the sample, 1,393 participants had never been in foster care, 22 participants had been in one foster care placement, 36 participants had been in multiple foster care placements, and 73 participants had been reunified with their parents after previously being in the foster care system. Of those within the sample, 900 participants were allocated to the child group, with ages ranging between 3.5 and 12 years. Of the total sample, 624 participants were allocated to the adolescent group, with ages ranging from 13 to 18 years.

Measures

Child Behaviour Checklist (CBCL; Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001). The CBCL is a widely used assessment tool used to measure emotional and behavioural problems in children. Two versions of the CBCL are available; a preschool checklist used to assess children aged between 18 months and 5 years, and a school version used to assess children aged between 6 and 18 years old. The CBCL checklist utilises responses from parents, teachers, and children who are aged between 11 and 18 years. Collectively, the responses are scored to provide information on a number of syndromes; Anxious/Depressed,

Withdrawn, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Delinquent Problems, and Aggressive Behaviour. Furthermore, scores are computed to provide an overall Internalising score, Externalising score, and Total Problems score. A large research base indicates that the CBCL has sound psychometric properties. Research indicates sound test-retest reliability, internal consistency, content validity, construct validity, and criterion-validity (Achenbach, 1991; Cohen, Gotlieb, Kershner, & Wehrspann, 1985; Leiner, Rescorla, Medina, Blanc, & Ortiz, 2010; Ivanova, et al., 2007; Rescorla et al., 2007).

Achenbach and Rescorla (2001) reported Test-Retest Reliability scores between $r=.82$ and $r=.94$ for the individual CBCL syndromes. Similar psychometric statistics were reported by Leiner et al. (2010) who assessed the psychometric properties of the English and Spanish versions of the CBCL using a community sample. Leiner and colleagues reported Cronbach alpha values ranging between .72 and .98 for the CBCL domains of the English version, and values between .70 and .97 for the Spanish version. Studies have also found the CBCL to possess strong cross-cultural generalisability, found to be suitable for use in over 30 countries (De Groot, Koot, & Verhulst, 1994; Ivanova et al., 2007; Rescorla et al., 2007).

Procedure

The Eastern Health and Royal Children's Hospital Ethics Review Boards granted ethical approval for the use of the data. Children who attended the ACPU were submitted to a full psychiatric assessment in which questionnaires and interviews were administered to obtain a comprehensive range of information regarding the child and their family. Assessment included obtaining information

about the child from both the child's parents and teachers. Parental consent was obtained prior to all assessments. Details regarding demographic, medical (primarily, neurological and endocrinological), educational, psychological, familial and social information were gathered at each assessment. All psychological data were collected by research assistants, who were advanced doctoral students in clinical psychology, trained and supervised by two registered clinical psychologists. All required data were archived from the ACPU database. Participants in the data base were categorized into one of four groups for the purpose of the analyses, based on their experience with the foster care system; participant's who had never been in foster care, participant's who had experienced one foster care placement, participant's who had experienced multiple foster care placements, and participant's who had been reunified with their parents following an experience in the foster care system. In addition, participants were allocated into one of three age categories; early childhood (0 to 7), middle childhood (8 to 12), and adolescence (13 years and above). Based on the small number of participants identified as early childhood aged, both the early childhood and middle childhood categories were collapsed into one group classified as 'childhood', for the purpose of the analyses.

Statistical procedures

A multivariate analysis of variance (MANOVA) was conducted to examine the effects of foster care status (no foster care placement, one foster care placement, multiple foster care placements, reunified) and age (childhood, adolescence) on psychopathological symptomatology (total problems, externalizing problems, internalizing problems, anxious/depressed, withdrawn, somatic complaints, social

problems, thought problems, attention problems, delinquent behaviour, aggressive behaviour). Univariate post-hoc tests were analyzed to explore significant group differences.

Results

Parametric statistical analyses were conducted using the Statistical Package for Social Sciences, Twenty-First edition (SPSS21). Prior to running the analyses, data screening procedures were used to assess the appropriate assumptions for the parametric tests being performed. A number of assumptions relevant to the MANOVA analysis were explored; normality, multicollinearity, outliers, linearity, and homogeneity of variance-covariance matrices. Some violations were detected and dealt with accordingly.

A two-way between-groups multivariate analysis of variance was performed to investigate the impact of foster care status and age on psychopathology. Eleven dependant variables measuring different domains of psychopathology were used: anxious/depressed, withdrawn, somatic complaints, social problems, thought problems, attention problems, delinquent problems, aggressive behaviour, internalizing problems, externalizing problems, and total problems. The independent variables included foster care status (never in foster care; foster care one placement; foster care multiple placements; reunified), and age (children; adolescents). In cases where the null hypothesis was rejected, post-hoc follow up tests were utilized to analyze group differences.

Findings of the data screening are presented primarily. The descriptive statistics for each study variable are then interpreted. Finally, the results are then presented in order of the study hypotheses.

Data Screening

An explorative analysis was used to screen for univariate assumptions. Interpretation of the Shapiro-Wilk tests and boxplots indicated non-normal distributions for many of the variables. This was an expected result given that the study sample included only clinical cases, which would render it unlikely for scores on emotional and behavioural assessments to be distributed in a specific pattern. Allen and Bennett (2012) reported that the MANOVA procedure is fairly robust against normality violations when group sizes are larger than approximately 30, which was the case for some groups within the analyses. Consequently, the analyses were continued without altering the data, so as to retain a true representation of the clinical scores.

A multiple regression analysis was conducted to assess multivariate assumptions. Regarding multicollinearity, some of the dependant variables were highly correlated, with a Pearson coefficient above 0.80. This was expected and likely unavoidable due to the fact that each dependant variable is a measure of the same concept; psychopathology. However, the total externalizing scale and the aggressive behaviour scale were the only two dependent variables to obtain a correlation above 0.90, with a Pearson correlation coefficient of 0.97. According to Allen and Bennett (2012), multicollinearity is present when the correlation coefficient is above .90 and can be dealt with by either deleting one of the violating variables or combining the two. Given the theoretical basis for the high correlation between total externalizing problems and aggressive behaviour problems, deleting either variable, or combining the two, was deemed inappropriate as it would result in a loss of meaningful data. Interpretation of the Mahalanobis distance score indicated the presence of multivariate outliers. In relation to the significant multivariate

outliers detected, it was concluded that deletion of scores would result in a loss of meaningful data.

Examination of scatterplots indicated linear relationships between all dependent variables. Homogeneity of variance-covariance matrices could not be assumed, however, Stevens (2009) reported that it is rare to meet the assumption of homogeneity of variance-covariance matrices in real life samples. In cases where the homogeneity of variance-covariance matrices assumption has not been satisfied, the Pillai-Bartlett trace, Wilks' λ , and the Hotelling-Lawley trace have been found to be robust against such a violation (Stevens, 2009). Therefore, the test of Roy's largest root was specifically ignored for the purposes of the interpretation of the analyses. Pallant (2010) specifically suggests using the Pillai's Trace in circumstances where assumptions are violated due to this test being more robust against data problems.

Descriptive Statistics of Study Variables

Table 1 below displays the means and standard deviations for the CBCL Subscale T-scores, as categorised by foster care status. Regarding the CBCL syndrome subscales, a T-score of 70 or above signifies a score that is clinically significant. A T-score between 67 and 70 represents a score within the clinical borderline range. For the Total Internalizing, Total Externalizing, and Total Problems subscales, a T-score above 63 is clinically significant, while a T-score between 60 and 63 signifies a score within the clinically borderline range.

Table 1

Means and Standard Deviations for CBCL Subscale T-scores in Relation to Foster Care Status

CBCL Scale	Never in foster care		foster care one placement		foster care multiple placements		Reunified	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Anxious/Depressed	67.13	11.31	62.28	8.86	67.32	11.17	67.23	11.36
Withdrawn	65.45	10.55	63.23	9.94	66.56	9.91	68.27	11.71
Somatic Complaints	62.95	9.84	61.73	7.21	62.47	8.31	63.00	10.24
Social Problems	66.69	10.51	66.36	11.08	71.61	8.68	69.96	10.67
Thought Problems	67.30	9.70	66.14	9.37	70.25	8.36	71.01	10.82
Attention Problems	69.28	11.39	70.59	11.51	72.6	11.34	73.99	12.09
Delinquent Behaviour	66.18	9.61	70.59	7.64	71.86	9.31	73.33	8.96
Aggressive Behaviour	71.24	12.97	74.36	12.96	76.22	10.21	78.52	11.51
Internalizing	66.79	10.40	63.95	8.97	67.33	8.98	67.55	10.70
Externalizing	68.31	11.05	72.05	8.70	74.08	7.35	75.25	8.00
Total Problems	70.11	8.85	70.59	7.93	73.78	5.40	74.19	7.70

N = 1,524.

As depicted in Table 1, the mean scores on each CBCL subscale were above the borderline range at minimum, or approaching the borderline range, for all foster care status categories. On average, children and adolescents who were in foster care and had experienced only one placement obtained a lower T-score on each of the internalizing domains, including the overall Internalizing score. Children who had experienced multiple foster care placements or had been reunified tended to score more highly on average, with regard to internalizing symptomatology. Regarding the

externalizing domains and the overall externalizing score, children who had never been in foster care obtained lower scores on average, whereas children who had been reunified attained higher scores on average. Participants who had been reunified with their biological parents tended to score more highly on the Total Problems scale in comparison to other foster care status groups.

As follows, Table 2 represents the means and standard deviations for the CBCL subscale T-scores obtained by children who experienced foster care as categorised by age group.

Table 2

Means and Standard Deviations for CBCL Subscale T-Scores in Relation to Age

CBCL Scale	Children		Adolescents	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Anxious/Depressed	65.66	10.96	67.35	11.33
Withdrawn	65.92	10.17	67.91	11.71
Somatic Complaints	62.24	9.06	63.01	9.54
Social Problems	68.92	10.43	70.63	10.19
Thought Problems	68.37	10.19	71.49	9.74
Attention Problems	73.33	11.45	72.63	12.13
Delinquent Behaviour	72.41	7.69	72.51	9.86
Aggressive Behaviour	78.14	11.50	76.31	11.43
Internalizing	66.68	9.60	67.07	10.41
Externalizing	74.70	7.50	74.10	8.43
Total Problems	73.67	6.12	73.29	8.20

N = 133.

As demonstrated in table 2, children and adolescents experienced internalising and externalising symptoms to a similar degree. Adolescents tended to possess slightly more severe internalising problems on average, in comparison to prepubescent children. Children, however, obtained slightly greater scores on average with regard to the externalising domains of attention and aggression problems. Overall, children and adolescents obtained very similar total problem scores.

Relationship between Foster Care Status and Psychopathology

Results of the MANOVA indicated a significant effect of foster care status (never been in foster care, foster care one placement, multiple foster care placements, reunified) on the combined dependent variables, $F(33, 4524) = 2.26, p = .00$; Pillai's Trace = .049; partial $\eta^2 = .016$. Univariate post-hoc analyses were examined to assess each dependent variable in isolation. A Bonferroni adjusted alpha level of .004 was employed. No significant effects were found for the CBCL domains of Anxious/depressed, Withdrawn, Somatic Complaints, Social Problems, Thought Problems, and Internalizing Problems. Where significant differences were found for individual dependent variables, pairwise comparisons were interpreted to determine where the specific significant differences lied.

Scores on the Total Problems index differed significantly between foster care status groups, $F(3, 1516) = 6.19, p = .00$, partial $\eta^2 = .012$. Specifically, children who had been reunified possessed more severe psychopathological problems overall ($M = 74.19, SD = 7.70$) in comparison to participants who were never in foster care ($M = 70.11, SD = 8.85$), $p = .00$.

Externalizing domain scores also differed significantly between foster care status groups, $F(3, 1516) = 12.43, p = .00$, partial $\eta^2 = .024$. A significant difference was evident between participants never in foster care and participants who had experienced multiple foster care placements on externalizing symptomatology, $p = .002$. Individuals in multiple foster care placements experience more severe externalizing symptoms ($M = 74.08, SD = 7.35$) in comparison to those never in foster care ($M = 68.31, SD = 11.05$). Similarly, participants who had been reunified attained significantly higher externalizing scores ($M = 75.25, SD = 8.00$) than those who had never experienced foster care, $p = .00$.

A statistically significant effect on the Attention Problems domain was found, $F(3, 1516) = 4.53, p = .004$, partial $\eta^2 = .009$. A significant difference on attention problems was found between participants who had never been in foster care, and those who had been reunified, $p = .001$. On average, reunified children possessed more severe attention problems ($M = 73.99, SD = 12.09$) than those who had never been in foster care ($M = 69.28, SD = 11.39$).

Scores on the Delinquent Problems index were significantly different between the foster care groups, $F(3, 1516) = 16.66, p = .000$, partial $\eta^2 = .032$. Specifically, significant differences in delinquent problems were found between three pairs; never in foster care and one foster care placement ($p = .031$), never in foster care and multiple foster care placements ($p = .00$), and never in foster care and reunified ($p = .00$). Individuals who had experienced some form of foster care were found to possess higher delinquent scores than those who had never been in foster care. Specifically, individuals who were reunified experienced the greatest severity of delinquent problems ($M = 73.33, SD = 8.96$) in comparison to children and adolescents who never experienced foster care ($M = 66.18, SD = 9.61$), followed by those who experienced multiple foster care placements ($M = 71.86, SD = 9.31$), and those who had experienced one foster care placement ($M = 70.59, SD = 7.64$), respectively.

A significant difference was also found between foster care categories on the Aggressive Behaviour scale, $F(3, 1516) = 8.72, p = .00$, partial $\eta^2 = .017$. Children and adolescents who experienced multiple foster care placements were found to attain significantly higher scores on the measure of aggressive behaviour ($M = 76.22, SD = 10.21$), compared to children and adolescents who were never in foster care ($M = 71.24, SD = 12.97$), $p = .021$. Similarly, reunified individuals possessed

significantly more severe aggressive problems ($M = 78.52$, $SD = 11.51$) than those who never experienced foster care, $p = .00$.

As predicted, externalizing symptoms were found to be more prevalent among the sample than internalizing symptoms, with overall mean T-scores of 71.88 ($SEM = .85$) and 65.86 ($SEM = .81$), respectively.

Relationship between Age and Psychopathology

Findings of the MANOVA indicated a significant overall effect of age (children versus adolescents) on the combined dependant variables, $F(11, 119) = 2.63$, $p = .005$; Pillai's Trace = .196; partial $\eta^2 = .196$. Further inspection of the between subjects effects indicated no effect of age on each dependent variable considered in isolation. Finally, no significant interaction effect was found for foster care status and age category on psychopathological symptoms.

Discussion

A number of children and adolescents require Child Protection intervention due to the maltreatment experienced in the home environment provided by their biological parent(s). In some cases, this requires removal from the home environment and placement in foster care. It is important to gain an in-depth understanding into the wellbeing of foster care children in order to delineate the appropriate strategies and supports necessary to facilitate smooth transitions in and out of the foster care system, ultimately advocating for the children's psychological wellbeing. The present study aimed to provide insight into the impact of different

foster care experiences on the psychological status of children in the foster care system. The findings of this research, indeed, indicate that different foster care experiences have different implications for the wellbeing of these children and adolescents.

The results of the current study provided support for some of the anticipated findings. Indeed, the severity of psychopathological symptoms differed among the foster care categories, and partial support was found for the prediction that children who experienced multiple foster care placements would experience behavioural problems most severely, followed by those who had been reunified, those who had experienced one foster care placement, and those who had never been in foster care. Additionally, the hypothesis that externalising symptoms would be more prevalent than internalising symptoms was supported. Results did not provide support for the hypothesis that adolescents would attain significantly higher rates of psychopathology than younger children. As follows, the interpretations of the findings are presented in order of hypotheses, excluding the hypothesis regarding suicidality.

Relationship between Foster Care Status and Psychopathology

Results of the study provided partial support for the hypothesis that children who experienced multiple foster care placements would attain the highest scores on a measure of psychopathological problems, followed by individuals who had been reunified, those who had experienced one foster care placement, and those who had never experienced foster care. Further, externalising symptoms were found to be more prevalent than internalising symptoms, as anticipated.

Regarding the experience of psychopathological symptoms among the different foster care categories, the pattern of results was generally what was expected although not all differences were found to be statistically significant, and it was only the overall total symptoms and externalising symptoms that differed among groups. Also, in some cases, reunified children were found to be fairing worse than those who had experienced multiple foster care placements. Due to the clinical nature of the sample comprising only children and adolescents who required hospital-based assessment for mental health related problems, it is not surprising that scores on the CBCL did not differ greatly among the different groups. Despite the small differences in a statistical sense, the pattern of results is considered to provide meaningful insight into the study's predictions.

Consistent with previous research by Kerker and Dore (2006), children in foster care generally experienced greater levels of psychopathological symptoms in comparison to children who had never experienced foster care. In particular, it was reunified children who experienced the most severe overall total problems, followed by individuals who experienced multiple foster care placements. Similarly, when considering each CBCL domain in isolation, it was the children and adolescents who had either experienced multiple foster care placements, or had been reunified, who experienced more severe externalising symptoms on average. Such findings are consistent with previous research which indicates that children who experience multiple placement disruptions are at a greater risk for the manifestation or exacerbation of psychological and behavioural symptoms (e.g., Newton et al., 2000).

The current study's outcome of reunified foster care children experiencing the most severe psychopathological symptoms overall lends support to the findings of previous research by Taussic and colleagues (2001), who found that reunified

children possessed more severe behavioural problems. Considering the premorbid history and environmental experiences of both reunified children and those who experienced multiple foster care placements, it is unsurprising that children in either of these categories possessed more severe psychopathological symptoms. Each of these environmental circumstances involves a likelihood of previous abuse, lack of security, instability, and the experience of multiple attachment traumas.

It has been speculated that reunified children were found to possess more severe overall total problems than children who experienced multiple placements due to the nature of the environment in to which they are returning. As indicated by Litrownik et al., (2003), foster care children who return to their biological parents are often returning to an adverse environment. At least that would be the case relative to the foster care environment in which they had been placed. Such environments may present a number of stressors, such as, exposure to violence and decreased parental support, which may potentially compromise the child's wellbeing and adjustment. Additionally, reunified children in this sample may have experienced multiple placement changes prior to their return home. This may place them in a worse position than those still within the foster care system given that returning home is in itself, an additional attachment trauma.

The number of children in foster care who experience multiple placement disruptions, or are reunified, is particularly concerning as each change in care characterises an attachment trauma. The experience of multiple attachment traumas may lead to a number of detrimental outcomes, such as, insecure attachment style and difficulty forming trusting relationships, difficulty forming attachments with new carers, reinforcement of feelings of abandonment, negative self-perceptions, and negative environmental perceptions (McClung, 2007; Osmond & Darlington, 2001).

Multiple attachment traumas may also lead to a number of negative outcomes long term. Individuals with attachment problems may later experience relationship difficulties, antisocial behaviour, conduct problems, criminality, anxiety disorders, emotional problems such as regulation difficulties, hostility, aggression, and poor romantic relationship adjustment (Allen, Hauser, & Borman-Spurrell, 1996; Riggs, Cusimano, & Benson, 2011; Scott, 2011).

Such findings of the study and past research regarding attachment trauma present a complex dilemma in terms of the decision to reunify foster care children with their biological parents. Although the research indicates that reunification may lead to poor psychological outcomes, reunification remains the primary goal of Child Protection intervention (Smyth & Eardley, 2008). Research has shown that even when biological parents have met the specified rehabilitation conditions to warrant reunification, reunification may still be inappropriate for the child's wellbeing (Dyer, 2004). It is important to consider how such problems associated with reunification may be rectified to lead to positive outcomes for foster care children.

Implementing appropriate parent interventions, above and beyond the specified reunification rehabilitation conditions, may be the key to successful reunification that leads to more positive outcomes for the reunified children. In light of attachment theory, co-parenting training may present an appropriate intervention to improve reunification outcomes. As discussed, attachment trauma plays a large role in the negative experiences and outcomes of entry into foster care, multiple placement disruption, and reunification. Literature highlights that the best approach to fostering positive attachments is to ensure that attachment bonds are maintained (Osmond & Darlington, 2001). Adopting a co-parenting approach to foster care

placements may provide a way for foster care children to sustain the attachment bonds they have with their biological parents during their stay in foster care.

Delfabbro, Barber, and Cooper (2002) reported that one form of regular parental contact can decrease the amount of time spent in foster care, and is also associated with successful reunification attempts. The form of contact may be direct or indirect, such as contact via the telephone. Indeed, literature has indicated positive adjustment outcomes with the implementation of co-parenting interventions (e.g., Linares, Montalto, Li, & Oza, 2006; Montalto, 2005). A study by Linares et al. (2006) assessed the outcome of implementing a 12-week co-parenting intervention with foster carers and biological parents of children in foster care who experienced externalising symptoms. Parents and carers who received the intervention were found to possess more positive parenting approaches upon completion of the program, in comparison to parents and carers who did not receive the program. At follow up, those who had received the intervention reported a decrease in the child's externalising symptoms.

When foster care children are exposed to attachment trauma, their ability to form close relationships and trust others becomes compromised, which can lead to the expression of aggression and other externalising behaviours (Allen et al., 1996). It is unsurprising then that co-parenting interventions would have positive outcomes regarding externalising symptoms, due to the nurturance of the primary attachment between the child and their biological parents. In addition to co-parenting interventions, the implementation of behavioural interventions may be beneficial to directly address the externalising symptoms experienced by foster care children.

In line with previous research (e.g., Steele & Buchi, 2008; Tarren-Sweeny & Hazell, 2006), externalising symptoms were found to be more prevalent among the current sample than internalising symptoms. Findings suggest it is more common for children to act out aggressively and defiantly, for example, than it is for them to experience symptoms such as withdrawal, anxiety, depression, and somatic problems. However, internalising symptoms may have been under-reported, as previously discussed. Regardless, the elevated externalising symptoms are particularly concerning given that previous research has indicated that externalising symptoms are a common factor leading to placement breakdown (e.g., Price et al., 2008), and that multiple placements are more detrimental to a child's adjustment than single placements (Taussig et al., 2001).

Unfortunately, the externalising symptoms that are experienced by foster care children are the very symptoms that render them vulnerable to placement disruption which, indeed, can lead to the exacerbation of symptoms (e.g., Fisher et al., 2011). Additionally, the experience of untreated externalising symptoms may have negative outcomes for these children's futures. The long term consequences of externalising behaviours may include negative experiences such as undermined adaptive functioning, undermined academic achievement, substance abuse, poor anger management, negative emotionality, and the manifestation or exacerbation of later internalising symptoms (Masten, et al., 2005; Winters, Stinchfield, Latimer, & Stone, 2008). Additionally, it can lead to an increase in risk of engaging in acts of juvenile delinquency, violent behaviour, and adult crime (Donner, 2010). Children may adjust more positively to foster care, and to future situations, with the appropriate supports in place to manage their behavioural symptoms.

Regarding internalising symptoms, results did not indicate a significant difference between individuals who had experienced foster care and those who had never been in foster care. This result may be understood with reference to past research that has indicated externalising symptoms are more prevalent among foster care children than internalising symptoms (e.g., Steele & Buchi, 2008; Tarren-Sweeny & Hazell, 2006). Still, scores on internalising symptoms were elevated among all groups which is unsurprising given that the current total sample was comprised of young people who had been referred for psychiatric assessment. It is necessary, however, to consider that the scores representing the children's and adolescents' internalising symptoms were provided by an adult informant rather than the participants themselves. Symptoms of children who had never experienced foster care would likely have been reported by a biological parent or guardian, whereas symptoms of children who were in foster care would likely have been reported by their foster carer. As such, data may not accurately represent the children's functioning in the sample.

According to research, adults' reports of children's internalising symptoms tend to be inconsistent with the child's self-reported symptoms (e.g., Achenbach, McConaughty, & Howell, 1987; Phares, Compas, & Howell, 1989), whereby parents and other informants tend to under-report the child's internalising symptoms (e.g., Stanger & Lewis, 1993). As such symptoms are experienced internally, they may be difficult to recognise without a child's verbal indication of their experience. It may then be postulated that foster carers are even less capable of accurately reporting a child's internalising symptoms, given the nature of their relationship and the limited length of time spent with the child. Perhaps children in the foster care system do not hold the same strong bond to their carer(s) as children would to their biological

parents, which in turn impacts on their ability to feel comfortable in expressing their emotional problems. Therefore, children in foster care may be experiencing more severe internalising symptoms compared with children never in foster care, but these symptoms are not properly recognised or reported.

Relationship between Age and Psychopathology

The current findings did not provide support for the hypothesis that adolescents would experience more severe psychopathological symptoms in comparison to younger children. In general, there was very little difference between age status and the severity of psychological symptoms. Therefore, it appears that although a greater number of adolescent foster care children possess psychopathological symptoms (e.g., Tarren-Sweeny & Hazell, 2006), the nature of their problems does not differ greatly from those younger children in foster care with mental health or adjustment difficulties.

Previous research has tended to explore the rates of psychopathology among foster care children. Studies have found that a higher percentage of adolescent aged foster care children experience significant psychopathological symptoms than younger children (Janssens & Deboutte, 2010; NSCAW, 2003; Steele & Buchi, 2008). Given that adolescents are at a greater risk of experiencing placement disruption than younger children (e.g., Fratter et al., 1991), and that multiple placement disruption leads to an exacerbation of psychological symptoms (e.g., Fisher et al., 2011), it was anticipated that adolescents would experience psychopathological symptoms to a more severe degree than younger children.

It may be proposed that results did not show a difference between age groups due to the fact that the study did not and could not account for the age at entry into foster care. In light of previous research (e.g., Newton et al., 2000), it is postulated that adolescents who enter foster care at a young age, and have experienced multiple placement changes during their time in the system, are more likely to experience severe behavioural and emotional problems. It may be the case that a large number of adolescents in the sample entered foster care recently and, therefore, had not been in the system long enough to experience the negative effects of multiple placement disruption.

Further, it may be argued that individuals in the child age category did not attain significantly higher scores on the measure of psychopathology due to their early entry into foster care. As exposure to abuse and neglect can have a largely negative impact on mental wellbeing (Lamont, 2010), it is anticipated that children who enter the foster care system at an early age may experience better mental health outcomes, given that they are removed from the detrimental environment provided by their parents, in turn limiting their exposure to maltreatment. Evidently, further research is imperative to elucidate the influence of age on psychopathology, particularly due to the conflicting and confusing findings of previous research.

Limitations of the Study

A major constraint of the present study is that a number of potentially influential factors could not be accounted for in the study due to the information available in the data set. Specifically, participants' age at entry into foster care and length of time spent in each foster care placement could not be considered.

Additionally, information was lacking regarding the type of intervention, if any, implemented with parents prior to reunification with their child. A statistical limitation of the study involved the highly unequal sample sizes. A very large portion of the sample had never been in foster care, which largely outweighed the number of participants who were allocated to one of the three foster care status groups. A problem with unequal sample sizes is that the statistical analyses may become more vulnerable to the production of type 1 errors. Additionally, only a small number of participants (22) were categorised as having experienced one foster care placement, which may have compromised statistical power for that particular foster care status category. Such statistical concerns indicate that the results of the study should be interpreted with caution.

Directions for Future Research

Further research is necessary to gain greater insight into the experiences of children in foster care, in order to elucidate the most appropriate measures that may be taken to improve their general wellbeing. An exploration into other factors that impact, positively or negatively, on the psychological wellbeing of foster care children would be of value. Further, with such a high prevalence rate of psychopathology among foster care children, it would be beneficial to explore their safety in terms of suicidality, particularly in light of the high level of depressive symptomatology, given the reported link between depression and suicidality (e.g. Nock, Hwang, Sampson, & Kessler, 2010).

Although research indicates that co-parenting interventions are valuable, it may be important to explore whether certain circumstances render the approach

inappropriate and damaging. For example, there may be cases where a child was exposed to severe abuse, and appreciates being removed from their parents care. Additional research into the influence of age on psychopathology is necessary to clarify the nature of the relationship between the two variables.

Conclusion

The findings of the current study indicate that children and adolescents who have experienced multiple placement disruptions, or who have been reunified with their biological parents, experience psychological symptoms to a worse degree than children who have experienced one foster care placement or have never been in foster care. Externalising symptoms were found to be more prevalent than internalizing symptoms, which is concerning given that externalizing symptoms exemplify a risk for placement breakdown. Each breakdown in placement presents an attachment trauma, which leads to negative outcomes in children. Indicatively, it is imperative to endeavour to provide a stable foster care experience for individuals in the foster care system, and much caution should be taken when considering reunification. Co-parenting interventions may be the appropriate approach to foster a continued attachment bond between the child and their parents, which may lead to a number of better outcomes; easier adjustment to the foster care system, shorter periods of time spent in foster care, and decreased likelihood of exacerbation of externalising symptoms in children.

Previous research regarding the influence of age on psychopathology in foster care children is both confusing and conflicting. The current findings indicate no considerable difference between the severity of symptoms experienced by children

and adolescents in the foster care system. Additional research is encouraged to provide further insight and clarity into such unanticipated findings. Overall, it is evident that children and adolescents who require foster care intervention are highly vulnerable to the manifestation and exacerbation of psychological and behavioural symptomatology. Further research into the factors that influence poor adjustment in the foster care system is encouraged, by means of delineating the appropriate strategies and supports that can be implemented to facilitate positive psychological wellbeing in foster care children and adolescents. It is anticipated that with the appropriate supports and interventions in place, children and adolescents may be facilitated to experience smoother transitions in and out of the foster care system, as well as limiting the number of placement disruptions, ultimately minimising their risk of exacerbated psychological symptoms.

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